YOUR EMPLOYER _____ POSITION _____

ADDRESS _____

SPOUSE NAME _____ WORK PHONE _____

SPOUSE EMPLOYER _____ POSITION _____

CLOSEST RELATIVE NOT LIVING WITH YOU:

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE# _____

CITY _____ STATE _____ ZIP _____

DENTAL INSURANCE INFORMATION

COORDINATION OF BENEFITS INFORMATION: If a patient is eligible for coverage under two or more dental care programs, a claim must be filed with each carrier. To determine the order of benefit payment, the plan covering the patient as the employee has the primary responsibility for payment before the plan covering the patient as a dependent. The primary carrier for dependent children is the plan covering the parent whose birthday (month and day) falls first in the year. The year of birth has no significance, if both parents have the same birthday, the plan in effect the longest is primary.

PRIMARY INSURANCE _____ PHONE _____

ADDRESS _____

_____

EMPLOYEE NAME _____ BIRTHDATE _____

ID/SOCIAL SECURITY # OF THE EMPLOYEE _____ GROUP # _____

EMPLOYER THAT HOLDS THE INSURANCE _____

SECONDARY INSURANCE _____ PHONE _____

ADDRESS _____

_____

EMPLOYEE NAME _____ BIRTHDATE _____

ID/SOCIAL SECURITY # OF THE EMPLOYEE _____ GROUP # _____

EMPLOYER THAT HOLDS THE INSURANCE _____

Is this a Worker's Compensation Claim? _____

I certify that all the above information is correct and that the signee is financially responsible.

DATE _____ SIGNATURE _____

PLEASE INITIAL AND DATE THAT YOU HAVE REVIEWED AND NOTED ANY NECESSARY CHANGES.

Initial _____ Date _____ Initial _____ Date _____ Initial _____ Date _____